

11302

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 3yrs 4mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Murray Middle (NMI) Last Berger		4. DATE OF DEATH Month 10 Day 19 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-06
9. AGE (In years last birthday) yrs. 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	11. BIRTHPLACE (State or foreign country) New York City, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis Berger	
14. MOTHER'S MAIDEN NAME Bertha Roman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II	
16. SOCIAL SECURITY NO. 125-07-5923		17. INFORMANT Address Hospital Records, VAH, Perry Point, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral unresolved 083.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Encephalitis chronic with paralysis agitans (Parkinsonian syndrome) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7-10 days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-20 , 19 56 , to 10-19 , 19 59 , and that death occurred at 12:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md. DATE SIGNED ACTUAL SIGNATURE J. L. Garey M.D. PHYSICIAN'S NAME (Type) J. L. GAREY Clinical Pathologist			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-20-59	
22c. NAME OF CEMETERY OR CREMATORY Mt Carmel		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE JACK LEWIS, INC. 2100 Eutaw Place, Baltimore Md.		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE Charles E. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 20 59

CERTIFICATE OF DEATH

11302

Deceased

Birth date

Place of birth

Place of death

Cause of death

Age

Sex

Marital status

SS

DOB

White

Male

Not known, New York City, N.Y.

Unknown

Family name

John J. Jones

John J. Jones, New York City, N.Y.

White

Male

Unknown, congenital dilated, uncorrected

Myocardial infarction with ventricular aneurysm

(Technical name optional)

Deceased's signature

SS

DOB

At home, New York City, N.Y.

Official certificate

J. J. JONES

John J. Jones, New York City, N.Y.

CERTIFICATE OF DEATH

Reg. Dist. No.

11270

11288

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lydia D. Brennan		4. DATE OF DEATH Month Day Year Oct. 14 1959	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1908
9. AGE (In years lost birthday) 51 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry O. Dean		14. MOTHER'S MAIDEN NAME Martha Holt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mr. Ralph H. Dean		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.1 Leukemia, Myelogenous - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Feb-1959			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1959 to Oct 14 1959, that I last saw the deceased alive on Oct 14 1959, and that death occurred at 2:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE [Signature] M.D. [Signature]		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/59	
22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk.		22d. LOCATION (City, town, or county) (State) nr. Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pippin Funeral Home [Signature] Elkton,		24a. REC'D BY REGISTRAR DATE OCT 20 '59	
		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11370

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

AS TO THE NAME OF THE DECEASED

[Faint, mostly illegible handwritten text follows, likely containing details of the deceased and the circumstances of death.]

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1-D, Film G250 10/22/59 iwk

11289

CERTIFICATE OF DEATH

Reg. Dist. No.

11271

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dennis Middle Burke Last Burke				4. DATE OF DEATH Month Oct. Day 1 Year 1959			
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1959		9. AGE (In years lost birthday) yrs. 8	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 8 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Male		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Donald Burke				14. MOTHER'S MAIDEN NAME Essie Brooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		INFORMANT Address Essie Burke- Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONITIS 756.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) IMPERFORATE ANUS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days FROM 10/13/59 9/26/59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/28 , 19 59 , to OCT 1 , 19 59 , that I last saw the deceased alive on OCT 1 , 19 59 , and that death occurred at 3:20 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry U. Davis				ADDRESS (Street, city or town, state) Chesapeake City, Md. DATE SIGNED 10/2/59			
PHYSICIAN'S NAME (Type) HENRY U. DAVIS MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/4/59		22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cem.		22d. LOCATION (City, town, or county) (State) Bohemia Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. R. Bell				ADDRESS 909 Poplar St.		24a. REC'D BY REGISTRAR DATE OCT 5 7 '59	
				24b. REGISTRAR'S SIGNATURE Charles A. Kenna			

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CERTIFICATE OF DEATH

1929

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CITY OF ST. LOUIS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11272

11303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u> c. LENGTH OF STAY IN 1b <u>all life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Lewis Calvert</u>			4. DATE OF DEATH Month Day Year <u>10 14 19 59</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-1902</u>		9. AGE (In years last birthday) <u>57</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting Houses</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>			
13. FATHER'S NAME <u>Robert Calvert</u>			14. MOTHER'S MAIDEN NAME <u>Belle Lewis</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-07-9783</u>		17. INFORMANT Address <u>Mary Murphy, Charlestown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Partial decapitation of left side of head</u> <u>976X</u> DUE TO (b) <u>with 12 gauge Single barrel Shot gun.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>12-50</u> <u>10 14 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Charlestown</u>		(County) <u>Cecil</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R.C. Dodson</u>			DATE SIGNED <u>10-14-59</u>				
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-16-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Charlestown Cemetery, Charlestown, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son, Perryville, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hines</u>		24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>3 wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> 14X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home - 224 E Main</u>				d. STREET ADDRESS <u>Tranquility Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>W.</u> Last <u>Coleman</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 9, 1891</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wahuman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>fishing</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>W. M. Coleman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-20-9908</u>		17. INFORMANT <u>Mr. Wesley Coleman - Rock Hall, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>610X Hypertrophied Prostate.</u> DUE TO (b) <u>& retention</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis - general.</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Sept. 16, 1959</u> to <u>Oct 12, 1959</u> , that I last saw the deceased alive on <u>Oct. 11, 1959</u> , and that death occurred at <u>8:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Ford H. Spence Jr. M.D.</u>				DATE SIGNED <u>Oct 12</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cem.</u>		22d. LOCATION (City, town, or county) <u>Rock Hall, Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin Williams - Chestertown Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR _____ DATE <u>OCT 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11274

Reg. Dist. No.

11291

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			c. LENGTH OF STAY IN TB <u>22 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Elkton, R.D. 3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital Elkton, Md.</u>				d. STREET ADDRESS <u>Pleasant Hill</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Webb</u> Middle <u>D</u> Last <u>Cox</u>				4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>19 59</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>1-4-1890</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Ash Co. N.C.</u>	
13. FATHER'S NAME <u>William Cox</u>				14. MOTHER'S MAIDEN NAME <u>Cora Kneades</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-32-0167</u>		17. INFORMANT <u>Fred H. Cox, Elkton, R.D. 1 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound right side of head above right temple bone with loos of blood and</u> DUE TO (b) <u>brain tissue</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) </div> <div style="width: 65%;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>22pistol shot self</u>			
20c. TIME OF INJURY Month, Day, Year <u>10-23-59</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Elkton R.D. 3 Cecil Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>10-24-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-26-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Union Cecil Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>				ADDRESS <u>ELKTON Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 27 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton S. House</u>				24c. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records or for a burial, cremation, or removal permit. File pages 1 and 2 with the registrar.

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2004

11304

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				c. LENGTH OF STAY IN 1b Lifetime			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First J Middle Edward Last Davis				4. DATE OF DEATH Month October Day 15 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1874	
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist				10b. KIND OF BUSINESS OR INDUSTRY Drug		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John T. Davis				14. MOTHER'S MAIDEN NAME Catherine L. Lake			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 327-03-9184		17. INFORMANT Address Cornelia W. Pratt, North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO cardio vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Suddenly 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954, 19, to Oct. 15, 1959, that I last saw the deceased alive on Oct. 14, 1959, and that death occurred at 7A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) North East, Maryland DATE SIGNED							
ACTUAL SIGNATURE H.A. Cantwell, M.D.				M.D. North East, Maryland			
PHYSICIAN'S NAME (Type) H.A. Cantwell, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-1959		22c. NAME OF CEMETERY OR CREMATORY North East, Methodist		22d. LOCATION (City, town, or county) (State) North East Cecil Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Maryland				24a. REC'D BY REGISTRAR DATE OCT 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

11276

11305

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CECIL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CECIL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rising Sun</u>		LENGTH OF STAY (in this place) <u>10 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rising Sun</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D.</u>				STREET ADDRESS (If rural give location) <u>R.D.</u>			
3. NAME OF DECEASED (Type or Print) <u>William F. Edwards</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 25, 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>August 18, 1867</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathanial Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Chapel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>RD#2, Box 86 Mrs. Elizabeth E. Sheridan Aberdeen, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
450.0 IMMEDIATE CAUSE (A) <u>Bronchial Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Oct 20 & 25 1959</u> <u>4 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 19, 1959</u> to <u>Oct 25, 1959</u> , that I last saw the deceased alive on <u>Oct 26, 1959</u> , and that death occurred at <u>8:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Joseph W. Foster</u> M.D.				ADDRESS (Street, city, town, state) <u>Washington Md - 10/26/59</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>OCT 28, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fountain Green, Bel Air, Harf. Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John E. K.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway + W. 1100 St. BEL AIR, Maryland</u>			
DATE <u>OCT 28 '59</u>							

CERTIFICATE OF DEATH

11305

Reg. Dist. No.

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX OF BIRTH

12. AGE OF BIRTH

13. OCCUPATION OF BIRTH

14. CAUSE OF BIRTH

15. MANNER OF BIRTH

16. DATE OF BIRTH

17. TIME OF BIRTH

18. PLACE OF BIRTH

19. DATE OF BIRTH

20. SEX OF BIRTH

21. AGE OF BIRTH

22. OCCUPATION OF BIRTH

23. CAUSE OF BIRTH

24. MANNER OF BIRTH

25. DATE OF BIRTH

26. TIME OF BIRTH

27. PLACE OF BIRTH

28. DATE OF BIRTH

29. SEX OF BIRTH

30. AGE OF BIRTH

31. OCCUPATION OF BIRTH

32. CAUSE OF BIRTH

33. MANNER OF BIRTH

34. DATE OF BIRTH

35. TIME OF BIRTH

36. PLACE OF BIRTH

37. DATE OF BIRTH

38. SEX OF BIRTH

39. AGE OF BIRTH

40. OCCUPATION OF BIRTH

41. CAUSE OF BIRTH

42. MANNER OF BIRTH

43. DATE OF BIRTH

44. TIME OF BIRTH

45. PLACE OF BIRTH

46. DATE OF BIRTH

47. SEX OF BIRTH

48. AGE OF BIRTH

49. OCCUPATION OF BIRTH

50. CAUSE OF BIRTH

51. MANNER OF BIRTH

52. DATE OF BIRTH

53. TIME OF BIRTH

54. PLACE OF BIRTH

55. DATE OF BIRTH

56. SEX OF BIRTH

57. AGE OF BIRTH

58. OCCUPATION OF BIRTH

59. CAUSE OF BIRTH

60. MANNER OF BIRTH

61. DATE OF BIRTH

62. TIME OF BIRTH

63. PLACE OF BIRTH

64. DATE OF BIRTH

65. SEX OF BIRTH

66. AGE OF BIRTH

67. OCCUPATION OF BIRTH

68. CAUSE OF BIRTH

69. MANNER OF BIRTH

70. DATE OF BIRTH

71. TIME OF BIRTH

72. PLACE OF BIRTH

73. DATE OF BIRTH

74. SEX OF BIRTH

75. AGE OF BIRTH

76. OCCUPATION OF BIRTH

77. CAUSE OF BIRTH

78. MANNER OF BIRTH

79. DATE OF BIRTH

80. TIME OF BIRTH

81. PLACE OF BIRTH

82. DATE OF BIRTH

83. SEX OF BIRTH

84. AGE OF BIRTH

85. OCCUPATION OF BIRTH

86. CAUSE OF BIRTH

87. MANNER OF BIRTH

88. DATE OF BIRTH

89. TIME OF BIRTH

90. PLACE OF BIRTH

91. DATE OF BIRTH

92. SEX OF BIRTH

93. AGE OF BIRTH

94. OCCUPATION OF BIRTH

95. CAUSE OF BIRTH

96. MANNER OF BIRTH

97. DATE OF BIRTH

98. TIME OF BIRTH

99. PLACE OF BIRTH

100. DATE OF BIRTH

101. SEX OF BIRTH

102. AGE OF BIRTH

103. OCCUPATION OF BIRTH

104. CAUSE OF BIRTH

105. MANNER OF BIRTH

106. DATE OF BIRTH

107. TIME OF BIRTH

108. PLACE OF BIRTH

109. DATE OF BIRTH

110. SEX OF BIRTH

111. AGE OF BIRTH

112. OCCUPATION OF BIRTH

113. CAUSE OF BIRTH

114. MANNER OF BIRTH

115. DATE OF BIRTH

116. TIME OF BIRTH

117. PLACE OF BIRTH

118. DATE OF BIRTH

119. SEX OF BIRTH

120. AGE OF BIRTH

121. OCCUPATION OF BIRTH

122. CAUSE OF BIRTH

123. MANNER OF BIRTH

124. DATE OF BIRTH

125. TIME OF BIRTH

126. PLACE OF BIRTH

127. DATE OF BIRTH

128. SEX OF BIRTH

129. AGE OF BIRTH

130. OCCUPATION OF BIRTH

131. CAUSE OF BIRTH

132. MANNER OF BIRTH

133. DATE OF BIRTH

134. TIME OF BIRTH

135. PLACE OF BIRTH

136. DATE OF BIRTH

137. SEX OF BIRTH

138. AGE OF BIRTH

139. OCCUPATION OF BIRTH

140. CAUSE OF BIRTH

141. MANNER OF BIRTH

142. DATE OF BIRTH

143. TIME OF BIRTH

144. PLACE OF BIRTH

145. DATE OF BIRTH

146. SEX OF BIRTH

147. AGE OF BIRTH

148. OCCUPATION OF BIRTH

149. CAUSE OF BIRTH

150. MANNER OF BIRTH

151. DATE OF BIRTH

152. TIME OF BIRTH

153. PLACE OF BIRTH

154. DATE OF BIRTH

155. SEX OF BIRTH

156. AGE OF BIRTH

157. OCCUPATION OF BIRTH

158. CAUSE OF BIRTH

159. MANNER OF BIRTH

160. DATE OF BIRTH

161. TIME OF BIRTH

162. PLACE OF BIRTH

163. DATE OF BIRTH

164. SEX OF BIRTH

165. AGE OF BIRTH

166. OCCUPATION OF BIRTH

167. CAUSE OF BIRTH

168. MANNER OF BIRTH

169. DATE OF BIRTH

170. TIME OF BIRTH

171. PLACE OF BIRTH

172. DATE OF BIRTH

173. SEX OF BIRTH

174. AGE OF BIRTH

175. OCCUPATION OF BIRTH

176. CAUSE OF BIRTH

177. MANNER OF BIRTH

178. DATE OF BIRTH

179. TIME OF BIRTH

180. PLACE OF BIRTH

181. DATE OF BIRTH

182. SEX OF BIRTH

183. AGE OF BIRTH

184. OCCUPATION OF BIRTH

185. CAUSE OF BIRTH

186. MANNER OF BIRTH

187. DATE OF BIRTH

188. TIME OF BIRTH

189. PLACE OF BIRTH

190. DATE OF BIRTH

191. SEX OF BIRTH

192. AGE OF BIRTH

193. OCCUPATION OF BIRTH

194. CAUSE OF BIRTH

195. MANNER OF BIRTH

196. DATE OF BIRTH

197. TIME OF BIRTH

198. PLACE OF BIRTH

199. DATE OF BIRTH

200. SEX OF BIRTH

201. AGE OF BIRTH

202. OCCUPATION OF BIRTH

203. CAUSE OF BIRTH

204. MANNER OF BIRTH

205. DATE OF BIRTH

206. TIME OF BIRTH

207. PLACE OF BIRTH

208. DATE OF BIRTH

209. SEX OF BIRTH

210. AGE OF BIRTH

211. OCCUPATION OF BIRTH

212. CAUSE OF BIRTH

213. MANNER OF BIRTH

214. DATE OF BIRTH

215. TIME OF BIRTH

216. PLACE OF BIRTH

217. DATE OF BIRTH

218. SEX OF BIRTH

219. AGE OF BIRTH

220. OCCUPATION OF BIRTH

221. CAUSE OF BIRTH

222. MANNER OF BIRTH

223. DATE OF BIRTH

224. TIME OF BIRTH

225. PLACE OF BIRTH

226. DATE OF BIRTH

227. SEX OF BIRTH

228. AGE OF BIRTH

229. OCCUPATION OF BIRTH

230. CAUSE OF BIRTH

231. MANNER OF BIRTH

232. DATE OF BIRTH

233. TIME OF BIRTH

234. PLACE OF BIRTH

235. DATE OF BIRTH

236. SEX OF BIRTH

237. AGE OF BIRTH

238. OCCUPATION OF BIRTH

239. CAUSE OF BIRTH

240. MANNER OF BIRTH

241. DATE OF BIRTH

242. TIME OF BIRTH

243. PLACE OF BIRTH

244. DATE OF BIRTH

245. SEX OF BIRTH

246. AGE OF BIRTH

247. OCCUPATION OF BIRTH

248. CAUSE OF BIRTH

249. MANNER OF BIRTH

250. DATE OF BIRTH

251. TIME OF BIRTH

252. PLACE OF BIRTH

253. DATE OF BIRTH

254. SEX OF BIRTH

255. AGE OF BIRTH

256. OCCUPATION OF BIRTH

257. CAUSE OF BIRTH

258. MANNER OF BIRTH

259. DATE OF BIRTH

260. TIME OF BIRTH

261. PLACE OF BIRTH

11306

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 1yr. 4mo. 23days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ARTHUR Middle E. Last EMMETT			4. DATE OF DEATH Month October Day 13, Year 19 59				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-94		9. AGE (In years last birthday) 64		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Nav. Gun Fac.		10b. KIND OF BUSINESS OR INDUSTRY Federal		11. BIRTHPLACE (State or foreign country) Halifax, N.S., Canada.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William J. Emmett				
14. MOTHER'S MAIDEN NAME Mary J. Babcock			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				
16. SOCIAL SECURITY NO. WW I 578-03-3480			17. INFORMANT Hospital Records, VAH, Perry Point, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA			
20f. (City or town) Perry Point		(County) (State)					
21. I certify that I attended the deceased from May 20 , 19 58 , to October 13, 1959 , from 7:45p and that death occurred at 7:45p M, from the causes and on the date stated above. ACTUAL SIGNATURE B. Rothfeld ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. 19-14-59 DATE SIGNED PHYSICIAN'S NAME (Type) B. ROTHFELD Asst. Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct 16-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln			
22d. LOCATION (City, town, or county) (State) Bladenburg Md		23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. Fun. Home, Good Hope Road S.E. Wash. D.C.					
24a. REC'D BY REGISTRAR OCT 15 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline					

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11278

11292

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 2 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Martha Frances Farrow		4. DATE OF DEATH Month Day Year 10 20 19 59	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-14-1890
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House work	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Cross		14. MOTHER'S MAIDEN NAME Ida Crawford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. 222-12-2365	
17. INFORMANT Address Lillian D. Clarke, Elkton, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebrovascular accident (b) 331X (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X (b) (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN DEATH AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 20, 1959, to Oct. 20, 1959, that I last saw the deceased alive on Oct. 20, 1959, and that death occurred at 7:15p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		DATE SIGNED 10/20/59	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D.		Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/59	
22c. NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery		22d. LOCATION (City, town, or county) (State) Wilmington, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Walter duBois, Jr.		24a. REC'D BY REGISTRAR ADDRESS Elkton Md	
24b. REGISTRAR'S SIGNATURE		DATE OCT 23 '59	

RECEIVED
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CHIEF OF POLICE

11292

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CHIEF OF POLICE

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CHIEF OF POLICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11293

CERTIFICATE OF DEATH

11279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural North East			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Curtis Middle C. Last Ford				4. DATE OF DEATH Month 10 Day 24 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-16-1885	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker				10b. KIND OF BUSINESS OR INDUSTRY Camp Chesapeake		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Daniel Ford				14. MOTHER'S MAIDEN NAME Annie -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Malcolm E. Ford				Address North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left lower lobe viral pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 min 5 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 23 Oct , 19 59 , to 24 Oct , 19 59 , that I last saw the deceased alive on 23 Oct , 19 59 , and that death occurred at 1 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North East, Md DATE SIGNED 24 Oct '59							
ACTUAL SIGNATURE Klaus H. Huebner M.D.				PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-1959		22c. NAME OF CEMETERY OR CREMATORY St. Mark's AUMP		22d. LOCATION (City, town, or county) (State) North East Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Maryland				24a. REC'D BY REGISTRAR DATE OCT 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2.88 1

11307

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun Rural</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/ d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>Mearns</u> Last <u>Gamble</u>				4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1919</u>		9. AGE (In years last birthday) yrs. <u>40</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Signal Maintainer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa. Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul Gamble</u>				14. MOTHER'S MAIDEN NAME <u>Blanche Slicer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-14-8972</u>		INFORMANT <u>Mrs. Helen J. Gamble, RFD, Rising Sun, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/1</u> , 19 <u>59</u> , to <u>10/29</u> , 19 <u>59</u> , that I lost saw the deceased alive on <u>10/29</u> , 19 <u>59</u> , and that death occurred at <u>5A M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil Taylor Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u> DATE SIGNED <u>10/29/59</u>			
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son</u>				ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 2 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Arnold</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR INSTATE OF DEATH

11301

MADE IN U.S.A.

11308

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Cremella		Middle Hammond		Last 10 15 19 59	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 13, 1906	
9. AGE (In years last birthday) 53		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel P. Jones				14. MOTHER'S MAIDEN NAME Susie Warrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Paul C. Hammond			
Address North East, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypernephroma of left kidney 180x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) — INTERVAL BETWEEN ONSET AND DEATH 21 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — — —						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) — — —	
21. I certify that I attended the deceased from 15 Apr. 1959 , to 15 Oct 1959 , that I last saw the deceased alive on 5 Oct 1959 , and that death occurred at 8 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town; state) North East, Md DATE SIGNED 16 Oct '59							
ACTUAL SIGNATURE Klaus H. Huebner		M.D. North East, Md					
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-19-1959		22c. NAME OF CEMETERY OR CREMATORY Trinity		22d. LOCATION (City, town, or county) (State) Zion Rural Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant Joseph R. Grant				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE OCT 19 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

11309

CERTIFICATE OF DEATH

Reg. Dist. No.

11282

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit, Rural</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Mary</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 / 25 // 1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William McNamee</u>				14. MOTHER'S MAIDEN NAME <u>Annie Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Howard D. Jackson Jr.</u> Address <u>Port Deposit, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Generalized Arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 yrs</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diphtheria, Hollitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>56</u> , to <u>27 Oct.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12 Oct.</u> , 19 <u>59</u> , and that death occurred at <u>12:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Klaus H. Huchner</u> M.D.				ADDRESS (Street, city or town, state) <u>No. 45 East Rd</u>		DATE SIGNED <u>10/27/59</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Huchner</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/31/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Rising Sun, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Vernon E. McMillan</u>				ADDRESS <u>Rising Sun Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased: *James M. Miller*
2. Date of death: *1944*
3. Place of death: *St. Louis, Mo.*
4. Cause of death: *Heart disease*
5. Age at death: *65*
6. Sex: *Male*
7. Race: *White*
8. Marital status: *Married*
9. Occupation: *Teacher*
10. Education: *High School*
11. Religion: *Catholic*
12. Burial place: *St. Louis, Mo.*
13. Name of funeral home: *St. Louis, Mo.*
14. Name of physician: *St. Louis, Mo.*
15. Name of undertaker: *St. Louis, Mo.*
16. Name of cemetery: *St. Louis, Mo.*
17. Name of church: *St. Louis, Mo.*
18. Name of family: *St. Louis, Mo.*
19. Name of friends: *St. Louis, Mo.*
20. Name of neighbors: *St. Louis, Mo.*

1. Name of deceased		2. Date of death		3. Place of death		4. Cause of death		5. Age at death		6. Sex		7. Race		8. Marital status		9. Occupation		10. Education		11. Religion		12. Burial place		13. Name of funeral home		14. Name of physician		15. Name of undertaker		16. Name of cemetery		17. Name of church		18. Name of family		19. Name of friends		20. Name of neighbors	
<i>James M. Miller</i>		<i>1944</i>		<i>St. Louis, Mo.</i>		<i>Heart disease</i>		<i>65</i>		<i>Male</i>		<i>White</i>		<i>Married</i>		<i>Teacher</i>		<i>High School</i>		<i>Catholic</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>	
1. Name of deceased		2. Date of death		3. Place of death		4. Cause of death		5. Age at death		6. Sex		7. Race		8. Marital status		9. Occupation		10. Education		11. Religion		12. Burial place		13. Name of funeral home		14. Name of physician		15. Name of undertaker		16. Name of cemetery		17. Name of church		18. Name of family		19. Name of friends		20. Name of neighbors	
<i>James M. Miller</i>		<i>1944</i>		<i>St. Louis, Mo.</i>		<i>Heart disease</i>		<i>65</i>		<i>Male</i>		<i>White</i>		<i>Married</i>		<i>Teacher</i>		<i>High School</i>		<i>Catholic</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>		<i>St. Louis, Mo.</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11283

Reg. Dist. No.

11310

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton R. D. #4		c. LENGTH OF STAY IN 1b 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elkton R. D. #4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Krusberg Last				4. DATE OF DEATH Month Oct. Day 29. Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1883		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Estonia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Krusberg				14. MOTHER'S MAIDEN NAME Mary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-01-1538		17. INFORMANT Mrs. Bertha Krusberg, R. D. #4, Elkton			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		10-30-59	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct. 31, 1959		22c. NAME OF CEMETERY OR CREMATORY ELKTON CEMETERY		22d. LOCATION (City, town, or county) (State) ELKTON, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS ELKTON, MD.		24a. REC'D BY REGISTRAR DATE NOV 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 11
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. POSTMORTEM FINDINGS	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF CLERK		22. SIGNATURE OF NURSE		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF PATHOLOGIST		25. SIGNATURE OF ANATOMIST	
26. SIGNATURE OF DENTIST		27. SIGNATURE OF OPTICIAN		28. SIGNATURE OF PHARMACEUTICIAN		29. SIGNATURE OF VETERINARIAN		30. SIGNATURE OF OTHER	
31. SIGNATURE OF CHURCH		32. SIGNATURE OF SCHOOL		33. SIGNATURE OF BUSINESS		34. SIGNATURE OF PROFESSION		35. SIGNATURE OF OTHER	
36. SIGNATURE OF FAMILY		37. SIGNATURE OF FRIENDS		38. SIGNATURE OF NEIGHBORS		39. SIGNATURE OF COMMUNITY		40. SIGNATURE OF OTHER	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF SURVIVORS		43. SIGNATURE OF ESTATE		44. SIGNATURE OF LEGAL		45. SIGNATURE OF OTHER	
46. SIGNATURE OF COURT		47. SIGNATURE OF JURY		48. SIGNATURE OF JUDGE		49. SIGNATURE OF CLERK		50. SIGNATURE OF OTHER	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF SURVIVORS		53. SIGNATURE OF ESTATE		54. SIGNATURE OF LEGAL		55. SIGNATURE OF OTHER	
56. SIGNATURE OF COURT		57. SIGNATURE OF JURY		58. SIGNATURE OF JUDGE		59. SIGNATURE OF CLERK		60. SIGNATURE OF OTHER	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF SURVIVORS		63. SIGNATURE OF ESTATE		64. SIGNATURE OF LEGAL		65. SIGNATURE OF OTHER	
66. SIGNATURE OF COURT		67. SIGNATURE OF JURY		68. SIGNATURE OF JUDGE		69. SIGNATURE OF CLERK		70. SIGNATURE OF OTHER	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF SURVIVORS		73. SIGNATURE OF ESTATE		74. SIGNATURE OF LEGAL		75. SIGNATURE OF OTHER	
76. SIGNATURE OF COURT		77. SIGNATURE OF JURY		78. SIGNATURE OF JUDGE		79. SIGNATURE OF CLERK		80. SIGNATURE OF OTHER	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF SURVIVORS		83. SIGNATURE OF ESTATE		84. SIGNATURE OF LEGAL		85. SIGNATURE OF OTHER	
86. SIGNATURE OF COURT		87. SIGNATURE OF JURY		88. SIGNATURE OF JUDGE		89. SIGNATURE OF CLERK		90. SIGNATURE OF OTHER	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF SURVIVORS		93. SIGNATURE OF ESTATE		94. SIGNATURE OF LEGAL		95. SIGNATURE OF OTHER	
96. SIGNATURE OF COURT		97. SIGNATURE OF JURY		98. SIGNATURE OF JUDGE		99. SIGNATURE OF CLERK		100. SIGNATURE OF OTHER	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11311

CERTIFICATE OF DEATH

11284

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Chester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 4yrs3mos23days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennett Square 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 312 Meredith St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle F. Last LEARY				4. DATE OF DEATH Month October Day 27 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 7, 1878	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JEREMIAH LEARY				14. MOTHER'S MAIDEN NAME MARY ANN FOLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes SAM (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown			
INFORMANT Hospital Records, VA Hospital, Perry Point, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis due to arteriosclerosis. 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from July 4, 1955 to October 27, 1959 , and that death occurred at 10:45AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md. DATE SIGNED 10-27-59							
ACTUAL SIGNATURE Richard H. Sundermann M.D.							
PHYSICIAN'S NAME (Type) RICHARD H. SUNDERMANN, M.D.							
22a. BURIAL, CREMATION, REMOVAL REMOVED		22b. DATE THEREOF 10-30-59		22c. NAME OF CEMETERY OR CREMATORY St Patricks Cemetery		22d. LOCATION (City, town, or county) (State) Kennett Square, Pa. 10-30-59	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. GRANT				ADDRESS North East, Md.		24a. REC'D BY REGISTRAR DATE OCT 29 '59	
				24b. REGISTRAR'S SIGNATURE Charles L. Kline			

MEDICAL CERTIFICATION

20

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K122

VA is pleased to have you as a member of the team.

J. H. TRANSDUCER, 1001012

2025-11-14 14:00:00

• 10-11-12 •

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11294

CERTIFICATE OF DEATH

Reg. Dist. No.

11285

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Agnes First Lewis Middle Last				4. DATE OF DEATH Oct. 7 Month Day Year 1959			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1871	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Sanders				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Clarence Rambo, Elkton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular Renal - 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 1 , 19 59 , to Oct 7 , 19 59 , that I last saw the deceased alive on Oct. 6 , 19 59 , and that death occurred at 12:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED Oct 7-59 ACTUAL SIGNATURE Milford H. Sprecher, M.D. PHYSICIAN'S NAME (Type) Milford H. Sprecher, M.D., Elkton, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/9/59		22c. NAME OF CEMETERY OR CREMATORY Charlestown Cemetery		22d. LOCATION (City, town, or county) (State) Charlestown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Peterson + Son ADDRESS Perryville, Md.				24a. REC'D BY REGISTRAR DATE OCT 13 '59		24b. REGISTRAR'S SIGNATURE Arthur A. Thomas	

CERTIFICATE OF DEATH

11304

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

STATE OF NEW YORK - BUREAU OF HEALTH

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 of 3 should be filled with the registrar for to burial, cremation, or removal, and in any event within 72 hours after death.

11312 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11286

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgan Nursing Home, Chesapeake City, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle V. Last Loveless		4. DATE OF DEATH Month Oct. Day 23, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1879
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas E. Meredith		14. MOTHER'S MAIDEN NAME Elizabeth Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-30-5004	
17. INFORMANT Mrs. Elizabeth Houston, New Castle, Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 31, 1959, to Oct. 23, 1959, that I last saw the deceased alive on Oct. 8, 1959, and that death occurred at 5:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. RALPH A NDREWS, JR., M.D.		ADDRESS (Street, city or town, state) 233 E. Main St. DATE SIGNED 10/24/59	
PHYSICIAN'S NAME (Type) S. RALPH A NDREWS, JR., M.D.		Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 27, 1959	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS Elkton, Md. DATE OCT 27 '59	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G250 10-27-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

11313

11287

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>				c. LENGTH OF STAY IN 1b <u>39 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARTHA</u> First Middle Last <u>LUZETSKY</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 22, 1890</u>	
9. AGE (In years lost birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>AUSTRIA</u> ✓	
13. FATHER'S NAME <u>PHILIP KANAK</u>				14. MOTHER'S MAIDEN NAME <u>Justina (Last name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT <u>ALEXANDER LUZETSKY, CHES.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardioma of stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10</u> , 19 <u>59</u> , to <u>Oct 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 17</u> , 19 <u>59</u> , and that death occurred at <u>2:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V. Davis</u> M.D.				ADDRESS (Street, city or town, state) <u>Chesapeake City, MD</u> DATE SIGNED <u>10/18/59</u>			
PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 20, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. ROSES</u>		22d. LOCATION (City, town, or county) (State) <u>CHESAPEAKE CITY, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		ADDRESS <u>ELCATON MD</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>OCT 22 '59</u>							

11587

CITIZENSHIP

1313

11

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "CITIZENSHIP" and "1313" are visible.]

11314

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural c. LENGTH OF STAY IN lb Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woodlawn		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural d. STREET ADDRESS Woodlawn e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle B. Marshall Last Marshall		4. DATE OF DEATH Month Oct. Day 13 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 23, 1905
9. AGE (In years last birthday) yrs. 54		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Gen. Store	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert B. Marshall	
14. MOTHER'S MAIDEN NAME Annie L. Thompson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 218-32-2319		INFORMANT Address Florence E. Marshall, Port Deposit, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) DUE TO Myocardial infarction Coronary Artery disease Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH idly
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/24 , 19 59 , to 10/13 , 19 59 that I last saw the deceased alive on 10/13/59 , 19 59 , and that death occurred at 5 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Irvin L. Wachsmen, M.D.		ADDRESS (Street, city or town, state) 407 S. Union Ave DATE SIGNED 10/13/59	
PHYSICIAN'S NAME (Type) Irvin L. Wachsmen, M.D.		Have de Guia vel	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-18-1959	22c. NAME OF CEMETERY OR CREMATORY Hopewell Cem.	22d. LOCATION (City, town, or county) Port Deposit, Md. Rural (State)
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son,		ADDRESS Perryville, Md.	24a. REC'D BY REGISTRAR DATE OCT 19 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

550

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b Less than 24			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 2502 Lakeland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOSEPH Middle C. Last MASER				4. DATE OF DEATH Month October Day 14 Year 19 59				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-5-20		
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic			10b. KIND OF BUSINESS OR INDUSTRY Refrigeration		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Maser				14. MOTHER'S MAIDEN NAME Elizabeth Siegrist				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II 218 10 6230		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>R. C. Dodson</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) R. C. DODSON				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-19-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Rd Baltimore Md		
23. FUNERAL DIRECTOR'S SIGNATURE Edward Foulson				24a. REC'D BY REGISTRAR DATE OCT 19 '59		24b. REGISTRAR'S SIGNATURE Charles S. Hanna		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased Joseph L. Lauer		Sex Male		Age 70	
Date of Death October 14, 1959		Place of Death Home		Residence 1205 Lexington Avenue, New York 17, N.Y.	
Cause of Death Myocardial infarction		Manner of Death Natural		Occupation None	
Signature of Medical Examiner W. C. Duggan		Signature of Coroner W. C. Duggan		Signature of Registrar W. C. Duggan	
Date of Signature October 14, 1959		Date of Signature October 14, 1959		Date of Signature October 14, 1959	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11290

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hacks Point Earville, R.D. 1. All life		c. LENGTH OF STAY IN 1b Earville, R.D. Hacks Point	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hacks Point		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle W Last May		4. DATE OF DEATH Month 10 Day 13 Year 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Road Laborer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph E. May		14. MOTHER'S MAIDEN NAME Sadie Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-12-1190	
17. INFORMANT Eugene May, Earville, R.D. 1, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Candilans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		DATE SIGNED 10-13-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT 11 1959	
22c. NAME OF CEMETERY OR CREMATORY JOHNTOWN CEM		22d. LOCATION (City, town, or county) (State) Johnstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward F. Dodson		24a. REC'D BY REGISTRAR OCT 21 '59	
ADDRESS Millington		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

— MEDICAL EXAMINER'S CERTIFICATE OF DEATH —

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Johnston, J. H. 1990. *Journal of the American Water Resources Association* 26: 101-110.

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TABLE 1. Continued

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CERTIFICATE OF DEATH

Reg. Dist. No. 11291

11317

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN lb 53 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cecil Ave.		e. STREET ADDRESS Cecil Ave.	
3. NAME OF DECEASED (Type or print) Mary Christina McCommons		4. DATE OF DEATH Oct. 31 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1874
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Smith		14. MOTHER'S MAIDEN NAME Pricilla Carr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mrs William W. White, Perryville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Sclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 19 months 8 yrs -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 20, 1959, to Oct. 30, 1959, that I last saw the deceased alive on Oct. 30, 1959, and that death occurred at M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Clarence I. Benson		Port Deposit, Md. 1959	
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 11-3-1959	22c. NAME OF CEMETERY OR CREMATORY Angel Hill	22d. LOCATION (City, town, or county) (State) Havre De Grace, Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. A. Patterson & Sons		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE NOV 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF CLAIM

1950

[Faint, illegible text and markings on a certificate form, including fields for name, address, and date.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11295

CERTIFICATE OF DEATH

11292

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ELKTON</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake City</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		d. STREET ADDRESS <i>—</i> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Baby</i> Middle Last <i>OTT</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>26</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 25, 1959</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	9. AGE (In years last birthday) <i>—</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <i>5 10</i>
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Walter L. Ott</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte COSNER</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i> INFORMANT Address <i>Walter L. Ott</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute respiratory failure</i> DUE TO <i>759.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Poorly developed respiratory system</i> DUE TO <i>5th</i> (c) <i>Pre-maturity</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-25</i> , 19 <i>59</i> , to <i>10-26</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>10-26</i> , 19 <i>59</i> , and that death occurred at <i>2:24</i> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Peter Stavrou</i> M.D. <i>154 W MAIN</i> <i>10-26-59</i>			
ACTUAL SIGNATURE <i>Peter Stavrou</i>		PHYSICIAN'S NAME (Type) <i>PETER STAVROU</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/27/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>ELKTON Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>ELKTON Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Walter du Bois, Jr.</i>		ADDRESS <i>Elkton, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>OCT 29 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanks</i>	

2065191XVO

CERTIFICATE OF DEATH

1905

1905

STATE OF NEW YORK

CERTIFICATE OF DEATH

Blank form with horizontal lines for text entry.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11294

11296

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 4 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Shallcross Last Poe				4. DATE OF DEATH Month October Day 8 Year 19 59					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 3, 1867			
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Hiram Whitaker Shallcross				14. MOTHER'S MAIDEN NAME Elizabeth L. Quick					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Margaret Dreydopple		Address Elkton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 hour		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>R. C. Dodson</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				October 9, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-11-1959		22c. NAME OF CEMETERY OR CREMATORY North East Methodist			22d. LOCATION (City, town, or county) (State) North East, Cecil, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Lantz</i>						ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE OCT 13 '59	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Burial Officer	
13. Signature of Undertaker		14. Signature of Funeral Home		15. Signature of Cemetery	
16. Signature of Church		17. Signature of Minister		18. Signature of Rector	
19. Signature of Pastor		20. Signature of Vicar		21. Signature of Chaplain	
22. Signature of Priest		23. Signature of Monk		24. Signature of Nun	
25. Signature of Friar		26. Signature of Brother		27. Signature of Sister	
28. Signature of Mother Superior		29. Signature of Abbess		30. Signature of Superior	
31. Signature of Mistress		32. Signature of Lady		33. Signature of Gentlewoman	
34. Signature of Gentleman		35. Signature of Esquire		36. Signature of Captain	
37. Signature of Major		38. Signature of Colonel		39. Signature of Lieutenant	
40. Signature of Sergeant		41. Signature of Corporal		42. Signature of Private	
43. Signature of Soldier		44. Signature of Sailor		45. Signature of Merchant	
46. Signature of Farmer		47. Signature of Laborer		48. Signature of Craftsman	
49. Signature of Tradesman		50. Signature of Artisan		51. Signature of Workman	
52. Signature of Journeyman		53. Signature of Apprentice		54. Signature of Student	
55. Signature of Scholar		56. Signature of Student		57. Signature of Teacher	
58. Signature of Professor		59. Signature of Lecturer		60. Signature of Professor	
61. Signature of Doctor		62. Signature of Surgeon		63. Signature of Physician	
64. Signature of Apothecary		65. Signature of Dispensary		66. Signature of Pharmacist	
67. Signature of Apothecary		68. Signature of Dispensary		69. Signature of Pharmacist	
70. Signature of Apothecary		71. Signature of Dispensary		72. Signature of Pharmacist	
73. Signature of Apothecary		74. Signature of Dispensary		75. Signature of Pharmacist	
76. Signature of Apothecary		77. Signature of Dispensary		78. Signature of Pharmacist	
79. Signature of Apothecary		80. Signature of Dispensary		81. Signature of Pharmacist	
82. Signature of Apothecary		83. Signature of Dispensary		84. Signature of Pharmacist	
85. Signature of Apothecary		86. Signature of Dispensary		87. Signature of Pharmacist	
88. Signature of Apothecary		89. Signature of Dispensary		90. Signature of Pharmacist	
89. Signature of Apothecary		90. Signature of Dispensary		91. Signature of Pharmacist	
90. Signature of Apothecary		91. Signature of Dispensary		92. Signature of Pharmacist	
91. Signature of Apothecary		92. Signature of Dispensary		93. Signature of Pharmacist	
92. Signature of Apothecary		93. Signature of Dispensary		94. Signature of Pharmacist	
93. Signature of Apothecary		94. Signature of Dispensary		95. Signature of Pharmacist	
94. Signature of Apothecary		95. Signature of Dispensary		96. Signature of Pharmacist	
95. Signature of Apothecary		96. Signature of Dispensary		97. Signature of Pharmacist	
96. Signature of Apothecary		97. Signature of Dispensary		98. Signature of Pharmacist	
97. Signature of Apothecary		98. Signature of Dispensary		99. Signature of Pharmacist	
98. Signature of Apothecary		99. Signature of Dispensary		100. Signature of Pharmacist	

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 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 11318
 CERTIFICATE OF DEATH

11295

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Md.				c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VAH., Perry Point				d. STREET ADDRESS 640 -W Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur N. Middle Ray Last Ray				4. DATE OF DEATH Month October Day 19, Year 19 59			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/12/92	
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Albert L. Ray				14. MOTHER'S MAIDEN NAME Nanny (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		INFORMANT VAH., Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Bilateral, unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease DUE TO (c) Unknown						INTERVAL BETWEEN ONSET AND DEATH 3/4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, Generalized, Severe						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from October 5, 19 59 to October 19, 19 59 and that death occurred at 7:50 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md. DATE SIGNED 10-20-59 ACTUAL SIGNATURE J. L. Garey M.D. Clinical Pathologist PHYSICIAN'S NAME (Type) J. L. GAREY, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/23/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE OCT 26 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

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CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

IN DAYS

AGE AT DEATH

CAUSE OF DEATH

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

AGE AT DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11296
Item 18 Film 250 10-27-59 ams										11297
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>UniCecil</u> <u>MD</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del</u> b. COUNTY <u>New Castle</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elsmere</u> <u>46 X-3</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle Last <u>Sachs</u>			4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1959</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/18/59</u>		9. AGE (In years lost birthday) <u>—</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>2</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Dr Kurt Sachs</u>					14. MOTHER'S MAIDEN NAME <u>Ruth Feldanger</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> [If yes, give war or dates of service]					16. SOCIAL SECURITY NO. <u>—</u>					
17. INFORMANT <u>Dr Kurt Sachs</u>					18. ADDRESS <u>Del City</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>Clifton R. Brooks</u>					ADDRESS (Street, city or town, state) <u>Main Street</u>					DATE SIGNED
PHYSICIAN'S NAME (Type) <u>Clifton R. Brooks</u>					Newark, Delaware					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-19-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>			22d. LOCATION (City, town, or county) (State) <u>Wilmington New Castle Del</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant, North East Md</u>					24a. REC'D BY REGISTRAR DATE <u>OCT 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>			

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CERTIFICATE OF DEATH

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1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 11319
 CERTIFICATE OF DEATH

11297

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 31yrs.1mo.26days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Bouckville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 69X-3 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRED Middle (NMI) Last SCHAEFFER		4. DATE OF DEATH Month October Day 14 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-28-90
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 14 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized severe - unknown INTERVAL BETWEEN ONSET AND DEATH unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 18 , 19 28 , to October 14 , 19 59 , and that death occurred at 2:00p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J. L. Garey M.D. V.A. Hospital, Perry Point, Md			
PHYSICIAN'S NAME (Type) J. L. GAREY Clinical Pathologist			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
10/20/59		10/20/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE October 26 '59	

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STATE OF OHIO

John Doe, Plaintiff
vs.
Jane Smith, Defendant

County of Hamilton

Verdict of the Jury

October 10, 1900

1-10-00

1-10-00

Male

New York

Lebanon

Unknown

Unknown

John Doe, Plaintiff

Unknown

1

Yes

Unknown

Cardiac disease

Cardiac disease - unknown

August 10, 1900

1-10-00

John Doe, Plaintiff

Clinical Pathology

1-10-00

John Doe, Plaintiff

John Doe, Plaintiff

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11298

Reg. Dist. No.

11298

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Elton Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anthony Middle J. Schneider Last				4. DATE OF DEATH Month 10 Day 19 Year 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/1891		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Grocery store		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No record				14. MOTHER'S MAIDEN NAME No record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1 221-03-5844		17. INFORMANT Mrs. May C. schneider		Address Cecilton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 hours years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Long-standing emphysema, severe. Hepato-renal failure with nephrosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 19 1956 , to 19 Oct 19 1959 , that I last saw the deceased alive on 19 Oct 19 1959 , and that death occurred at 12:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 20 Oct 59							
ACTUAL SIGNATURE Wallace Obenshain M.D.				PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D. Cecilton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 22, 1959		22c. NAME OF CEMETERY OR CREMATORY Johntown Cemetery		22d. LOCATION (City, town, or county) (State) Rural Earleville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward F. H. ...				24a. REC'D BY REGISTRAR DATE OCT 23 '59		24b. REGISTRAR'S SIGNATURE Cashus S. ...	

11288

CERTIFICATE OF DEATH

11288

COUNTY OF MARYLAND DISTRICT OF BALTIMORE		DEPARTMENT OF HEALTH BALTIMORE, MD.	
NAME OF DECEASED ALICE HODGES		SEX F	
AGE 10		DATE OF BIRTH 4/24/1907	
PLACE OF BIRTH BALTIMORE, MD.		OCCUPATION None	
MARITAL STATUS Single		CAUSE OF DEATH Infant death	
DATE OF DEATH 10/10/1917		PLACE OF DEATH HOME	
TIME OF DEATH 10:00 AM		SIGNATURE OF PHYSICIAN J. H. HODGES	
SIGNATURE OF WITNESS J. H. HODGES		SIGNATURE OF DECEASED None	
SIGNATURE OF CORONER J. H. HODGES		SIGNATURE OF JURY None	
SIGNATURE OF REGISTRAR J. H. HODGES		SIGNATURE OF CLERK J. H. HODGES	

This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, on the 10th day of October, 1917.

J. H. HODGES
 REGISTRAR

11299

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home				d. STREET ADDRESS R.D.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Anna Smith				4. DATE OF DEATH October 10, 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 20, 1892	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Alexander Osolo				14. MOTHER'S MAIDEN NAME Anna Osahla			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Edward J. Smith, Elkton, Md. R.D. 4			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute congestive heart failure DUE TO (c) A.H.D. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, Mellitus, Cerebral Vascular sclerosis INTERVAL BETWEEN ONSET AND DEATH 10 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June, 1958, to 10-10-59, that I last saw the deceased alive on 10-10-59, and that death occurred at 9:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 154 W. MAIN, ELKTON, MD. DATE SIGNED 10-12-59							
ACTUAL SIGNATURE Peter Smith				M.D. 154 W. MAIN, ELKTON, MD.			
PHYSICIAN'S NAME (Type) PETER STAVRAKIS M.D.				ELKTON, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/14/59		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE OCT 23 59	
				24b. REGISTRAR'S SIGNATURE Charles L. Knaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED BROWN, JOHN		2. SEX Male		3. AGE 45		4. DATE OF BIRTH Jan 15, 1875		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. DATE OF DEATH Dec 10, 1920		12. TIME OF DEATH 10:30 AM		13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural	
16. SIGNATURE OF PHYSICIAN J. H. Smith		17. SIGNATURE OF MINISTER J. H. Smith		18. SIGNATURE OF CORONER J. H. Smith		19. SIGNATURE OF DECEASED J. H. Smith		20. SIGNATURE OF WITNESSES J. H. Smith	
21. NAME OF FUNERAL HOME J. H. Smith		22. NAME OF CEMETERY J. H. Smith		23. NAME OF CLERGYMAN J. H. Smith		24. NAME OF MINISTER J. H. Smith		25. NAME OF CORONER J. H. Smith	
26. NAME OF DECEASED BROWN, JOHN		27. NAME OF DECEASED BROWN, JOHN		28. NAME OF DECEASED BROWN, JOHN		29. NAME OF DECEASED BROWN, JOHN		30. NAME OF DECEASED BROWN, JOHN	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. EDUCATION
9. RELIGION
10. RACE
11. DATE OF DEATH
12. TIME OF DEATH
13. PLACE OF DEATH
14. CAUSE OF DEATH
15. MANNER OF DEATH
16. SIGNATURE OF PHYSICIAN
17. SIGNATURE OF MINISTER
18. SIGNATURE OF CORONER
19. SIGNATURE OF DECEASED
20. SIGNATURE OF WITNESSES
21. NAME OF FUNERAL HOME
22. NAME OF CEMETERY
23. NAME OF CLERGYMAN
24. NAME OF MINISTER
25. NAME OF CORONER
26. NAME OF DECEASED
27. NAME OF DECEASED
28. NAME OF DECEASED
29. NAME OF DECEASED
30. NAME OF DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11300

CERTIFICATE OF DEATH

11300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>DuPort</u> Last <u>Thomson</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1869</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineering</u>	
11. BIRTHPLACE (State or foreign country) <u>Phila., Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>No Infor</u>		14. MOTHER'S MAIDEN NAME <u>No Info</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. Sonya Burgher</u>		Address <u>Rochester, N. Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular-renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10:00 a.m., Oct. 14, 1959</u> to <u>9:15 p.m., Oct. 14, 1959</u> that I last saw the deceased alive on <u>Oct. 14, 1959</u> , and that death occurred at <u>9:15 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Ford H. Spence</u> M.D.		DATE SIGNED <u>Oct 15, 1959</u>	
PHYSICIAN'S NAME (Type) <u>W. Ford H. Spence</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fredericksburg Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Fredericksburg, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Oct 20 1959</u>	
ADDRESS <u>Donald K. De</u> <u>Elkton</u>		24b. REGISTRAR'S SIGNATURE <u>Christina S. Knud</u>	

11300

CERTIFICATE OF DEATH

11300

23

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11301

11320

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton		c. LENGTH OF STAY IN 1b 4 Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Route # 40				d. STREET ADDRESS U.S. Route # 40		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEAH Middle TISHA Last TOMLINSON				4. DATE OF DEATH Month October Day 21, Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1894		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Antique Dealer		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Wray				14. MOTHER'S MAIDEN NAME Sarah Dudley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-5713		17. INFORMANT Address Dr. Wray J. Tomlinson Columbus, Ga.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/21-59	
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Oct. 23, 1959		22c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory		22d. LOCATION (City, town, or county) (State) Wilmington, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS Dorsey H. See Elkton, Md		24a. REC'D BY REGISTRAR DATE OCT 26 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar for a burial, cremation, or removal permit. File page 3 should be used as a burial-transit permit.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11321

CERTIFICATE OF DEATH

11302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural North East		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural North East	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Virginia Elizabeth Travers		4. DATE OF DEATH Month Day Year October 1 1959	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-1959
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George V. Travers	
14. MOTHER'S MAIDEN NAME Helen V. Veasey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]	
16. SOCIAL SECURITY NO.		17. INFORMANT Address George V. Travers North East Rd, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.0 Hyaline Membrane Disease of Lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 Sept, 1959, to 1 Oct, 1959, that I last saw the deceased alive on 1 Oct, 1959, and that death occurred at 5:45 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Huebner M.D.		ADDRESS (Street, city or town, state) North East Rd DATE SIGNED 1 Oct '59	
PHYSICIAN'S NAME (Type) Klaus H. Huebner			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 2, 1959	22c. NAME OF CEMETERY OR CREMATORY North East Methodist	22d. LOCATION (City, town, or county) (State) North East, Cecil, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Deant North East, Maryland		24a. REC'D BY REGISTRAR DATE OCT 2 '59	24b. REGISTRAR'S SIGNATURE

2065 263XU3

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

11 18

FILE NO.

<p>1. NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>2. SEX</p> <p><i>Male</i></p>		<p>3. AGE</p> <p><i>45</i></p>	
<p>4. DATE OF DEATH</p> <p><i>Jan 15 1918</i></p>		<p>5. TIME OF DEATH</p> <p><i>10:30 AM</i></p>		<p>6. PLACE OF DEATH</p> <p><i>Home</i></p>	
<p>7. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>8. DISEASE OR INJURY</p> <p><i>Myocardial Infarction</i></p>		<p>9. MANNER OF DEATH</p> <p><i>Natural</i></p>	
<p>10. SIGNATURE OF PHYSICIAN</p> <p><i>John Doe</i></p>		<p>11. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>12. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>13. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>14. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>15. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>16. MARITAL STATUS</p> <p><i>Married</i></p>		<p>17. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>18. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>19. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>20. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>21. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>22. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>23. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>24. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>25. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>26. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>27. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>28. MARITAL STATUS</p> <p><i>Married</i></p>		<p>29. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>30. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>31. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>32. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>33. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>34. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>35. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>36. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>37. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>38. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>39. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>40. MARITAL STATUS</p> <p><i>Married</i></p>		<p>41. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>42. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>43. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>44. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>45. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>46. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>47. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>48. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>49. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>50. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>51. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>52. MARITAL STATUS</p> <p><i>Married</i></p>		<p>53. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>54. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>55. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>56. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>57. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>58. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>59. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>60. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>61. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>62. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>63. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>64. MARITAL STATUS</p> <p><i>Married</i></p>		<p>65. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>66. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>67. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>68. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>69. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>70. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>71. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>72. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>73. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>74. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>75. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>76. MARITAL STATUS</p> <p><i>Married</i></p>		<p>77. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>78. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>79. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>80. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>81. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>82. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>83. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>84. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>85. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>86. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>87. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>88. MARITAL STATUS</p> <p><i>Married</i></p>		<p>89. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>90. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>91. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>92. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>93. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>94. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>95. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>96. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>97. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>98. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>99. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>100. MARITAL STATUS</p> <p><i>Married</i></p>		<p>101. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>102. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>103. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>104. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>105. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>106. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>107. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>108. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>109. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>110. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>111. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>112. MARITAL STATUS</p> <p><i>Married</i></p>		<p>113. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>114. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>115. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>116. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>117. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>118. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>119. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>120. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>121. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>122. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>123. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>124. MARITAL STATUS</p> <p><i>Married</i></p>		<p>125. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>126. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>127. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>128. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>129. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>130. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>131. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>132. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>133. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>134. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>135. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>136. MARITAL STATUS</p> <p><i>Married</i></p>		<p>137. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>138. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>139. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>140. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>141. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>142. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>143. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>144. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>145. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>146. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>147. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>148. MARITAL STATUS</p> <p><i>Married</i></p>		<p>149. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>150. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>151. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>152. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>153. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>154. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>155. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>156. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>157. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>158. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>159. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>160. MARITAL STATUS</p> <p><i>Married</i></p>		<p>161. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>162. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>163. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>164. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>165. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>166. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>167. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>168. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>169. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>170. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>171. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>172. MARITAL STATUS</p> <p><i>Married</i></p>		<p>173. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>174. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>175. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>176. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>177. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>178. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>179. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>180. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>181. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>182. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>183. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>184. MARITAL STATUS</p> <p><i>Married</i></p>		<p>185. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>186. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>187. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>188. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>189. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>190. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>191. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>192. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>193. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>194. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>195. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>196. MARITAL STATUS</p> <p><i>Married</i></p>		<p>197. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>198. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>199. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>200. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>201. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>202. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>203. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>204. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>205. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>206. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>207. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>208. MARITAL STATUS</p> <p><i>Married</i></p>		<p>209. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>210. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>211. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>212. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>213. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>214. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>215. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>216. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>217. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>218. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>219. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>220. MARITAL STATUS</p> <p><i>Married</i></p>		<p>221. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>222. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>223. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>224. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>225. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>226. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>227. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>228. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>229. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>230. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>231. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>232. MARITAL STATUS</p> <p><i>Married</i></p>		<p>233. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>234. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>235. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>236. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>237. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>238. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>239. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>240. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>241. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>242. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>243. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>244. MARITAL STATUS</p> <p><i>Married</i></p>		<p>245. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>246. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>247. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>248. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>249. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>250. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>251. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>252. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>253. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>254. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>255. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>256. MARITAL STATUS</p> <p><i>Married</i></p>		<p>257. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>258. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>259. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>260. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>261. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>262. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>263. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>264. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>265. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>266. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>267. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>268. MARITAL STATUS</p> <p><i>Married</i></p>		<p>269. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>270. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>271. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>272. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>273. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>274. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>275. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>276. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>277. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>278. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>279. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>280. MARITAL STATUS</p> <p><i>Married</i></p>		<p>281. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>282. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>283. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>284. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>285. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>286. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>287. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>288. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>289. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>290. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>291. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>292. MARITAL STATUS</p> <p><i>Married</i></p>		<p>293. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>294. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>295. PREVIOUS DEATHS</p> <p><i>None</i></p>		<p>296. PREVIOUS INJURIES</p> <p><i>None</i></p>		<p>297. PREVIOUS DISEASES</p> <p><i>None</i></p>	
<p>298. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>299. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>300. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>299. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>300. DATE OF BIRTH</p> <p><i>Jan 1 1873</i></p>		<p>301. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>300. MARITAL STATUS</p> <p><i>Married</i></p>		<p>301. NAME OF SPOUSE</p> <p><i>John Doe</i></p>		<p>302. DATE OF MARRIAGE</p> <p><i>Jan 1 1900</i></p>	
<p>301. PREVIOUS DEATH</p>					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11303

11322

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL PERRYVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL PERRYVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ISABELLA</u> First <u>WHERRY</u> Middle <u>W</u> Last				4. DATE OF DEATH <u>OCTOBER-21</u> Month <u>19</u> Day <u>59</u> Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUGUST 27-1857</u> - <u>102</u> yrs.	
9. AGE (In years last birthday) <u>102</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>GEORGE STOREY</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HICKMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. L. B. ROBERTS</u> Address <u>PERRYVILLE Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDITIS</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL SCLEROSIS</u> DUE TO (c) <u>ARTERIO-SCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u> <u>1 YR</u> <u>8 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept. 10, 1958</u> to <u>Oct. 20, 1959</u> , that I last saw the deceased alive on <u>Oct. 20, 1959</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence I. Benson</u> M.D.				DATE SIGNED <u>PORT-DEPOSIT</u>			
PHYSICIAN'S NAME (Type) <u>CLARENCE I. BENSON</u>				Box <u>123</u> <u>Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/25/59</u>		<u>New London Presby.</u>		<u>New London. Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u> ADDRESS <u>Rising Sun Ind.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
				DATE <u>OCT 26 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11323

CERTIFICATE OF DEATH

11304

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nottingham Pa. RD#2. 47</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nottingham Pa. RD#2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Bayard Grover Wilson</i>		4. DATE OF DEATH Month Day Year <i>Oct 16 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 9 1883 76 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Cecil County, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Wilson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Taylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>182-32-14N</i>	
17. INFORMANT <i>John W. Wilson</i>		Address <i>Nottingham Pa. RD#2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Adenocarcinoma of stomach</i> DUE TO (c) <i>Chronic Gastritis & esophagitis.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 months.</i> <i>1 year.</i> <i>20 years.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 1958, to <i>Oct. 16</i> , 1959; that I last saw the deceased alive on <i>Oct. 15</i> , 1959, and that death occurred at <i>11:55 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John S. Brittingham</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>205 Locust St., Oxford, Penna 10-16-59</i>	
PHYSICIAN'S NAME (Type) <i>John T. Brittingham</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 19, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Friends</i>		22d. LOCATION (City, town, or county) (State) <i>Calvert Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M Reed, Rising Sun, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 19 1959</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kline</i>			

11-12-1954

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 11301
 CERTIFICATE OF DEATH

11305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 39 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 1 Elkton, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Henry Seeds Young				4. DATE OF DEATH Month Day Year Oct. 14, 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 26, 1880	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate & Insurance				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wilmington, Del.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert Henry Young				14. MOTHER'S MAIDEN NAME Emily Seeds			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Nov. 1918				16. SOCIAL SECURITY NO. 220-18-5726			
17. INFORMANT Mrs. Henry S. Young				Address Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic coronary artery disease (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 18, 1957, to Oct. 14, 1959, that I last saw the deceased alive on Oct. 14, 1959, and that death occurred at 7:50 a. m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE [Signature] M.D. 233 E. Main St. 10/16/59 PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D. Elkton Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/59		22c. NAME OF CEMETERY OR CREMATORY Elkton Cem.		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home Donald G. Dee				24a. REC'D BY REGISTRAR OCT 20 '59		24b. REGISTRAR'S SIGNATURE C. E. K. K.	

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